Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN E EARLE MD
PO BOX 33577
SAN ANTONIO TX 78265

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-08-5828-01

MFDR Date Received
MAY 16, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Each one of these codes was preauthorized and cannot be denied by medical necessity per TDI-DWCC Guidelines."

Amount in Dispute: $8,637.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Values for reimbursed procedures correctly calculated per MAR or By-Report in accordance with TDI/DWC guidelines; multiple & bilateral procedure reduction guidelines correctly applied. Procedures denied for payment correctly on basis of documentation & /or AMACPT & NCCI guidelines. No procedures denied for payment due to lack of medical necessity."

Response Submitted by: Hoffman Kelley/Claims Management, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2007	CPT Code 63042-50	$369.62	$0.00
	CPT Code 63044-50	$960.14	$0.00
	CPT Code 63044-99	$420.29	$0.00
	CPT Code 63044	$420.29	$0.00
	CPT Code 63044-50	$960.14	$0.00
	CPT Code 63011-50	$300.37	$0.00
	CPT Code 62290-99	$201.94	$0.00
November 14, 2007	CPT Code 62290-22	$201.94	$0.00

	CPT Code 62290-59	$201.94	$0.00
	CPT Code 63685-59	$278.21	$219.03
	CPT Code 22851-59	$495.16	$0.00
	CPT Code 22851-50	$495.16	$0.00
	CPT Code 22842-50	$931.86	$0.00
	CPT Code 22325-59	$768.77	$768.76
	CPT Code 22328-59	$500.00	$334.20
	CPT Code 22328-22	$500.00	$334.20
	CPT Code 69990-59	$131.53	$0.00
	CPT Code 22899-99	$500.00	$0.00
TOTAL		$8,637.36	$1,656.19

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W1-Workers Compensation State Fee Schedule Adjustment.
- 59-Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 78-The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
- 97-Payment adjusted because the benefit for this service is included in the accordance with multiple surgical procedure rules and/or guidelines.
- 112-Billed service is not identified in the operative report.
- 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 271-The fee schedule does not include a value for the procedure code billed. An allowance has been made which is based on charges for similar/comparable services.
- 285-Please refer to the note above for a detailed explanation of the reduction.
- 300-An allowance has been made for a bilateral procedure.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 552-Billing of procedure is not appropriate for bilateral procedures.

- 903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery: Endocrine, nervous, eye and ocular adnexa, auditory systems procedure (60000-69999) has been disallowed.
- B12-Services not documented in patients medical records.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 5036-Complex bill – Reviewed by Medical Cost Analysis Team.

Issues

1. Does the submitted documentation support billing of a bilateral procedure for CPT code 63042? Did the requestor bill correctly in accordance with CMS policy? Is the requestor entitled to reimbursement for CPT code 63042-50?
2. Does the submitted documentation support billing of a bilateral procedure for CPT code 63044? Did the requestor bill correctly in accordance with CMS policy? Is the requestor entitled to reimbursement for CPT codes 63044, 63044-50(X2) and 63044-99?
3. Does the submitted documentation support billing of a bilateral procedure for CPT code 63011-50? Did the requestor bill correctly in accordance with CMS policy? Is the requestor entitled to additional reimbursement for CPT code 63011-50?
4. Is the allowance for CPT code 62290 included in the allowance of another procedure performed on the disputed date? Is the requestor entitled to reimbursement for CPT code 62290-99, 62290-59 and 62290-22?
5. Does the documentation support billing of CPT code 63685-59? Is the requestor entitled to reimbursement for CPT code 63685-59?
6. Did the requestor bill correctly in accordance with CMS policy for CPT code 22851-50? Is the requestor entitled to reimbursement for CPT code 22851-59 and 22851-50?
7. Did the requestor bill correctly in accordance with CMS policy for CPT code 22842-50? Is the requestor entitled to reimbursement for CPT code 22842-50?
8. Does the documentation support billing of CPT code 22325-59? Is the requestor entitled to reimbursement for CPT code 22325-59?
9. Does the documentation support billing of CPT code 22328-59 and 22328-22? Is the requestor entitled to reimbursement for CPT code 22328-59 and 22328-22?
10. Is the allowance for CPT code 69990 included in the allowance of another procedure performed on the disputed date? Is the requestor entitled to reimbursement for CPT code 69990-59?
11. Does the documentation support billing of CPT code 22899-99? Is the requestor entitled to reimbursement for CPT code 22899-99?

Findings

1. CPT code 63042 is defined as “Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar.”
    - The requestor appended modifier “50-Bilateral Procedure” to CPT code 63042.
    - The requestor billed for CPT code 63042 and 63042-50 for the initial level.
    - The requestor states in the position summary that “Code 63042-50 concerning L5-S1 bilaterally, at fair and reasonable charge of $1900 was made with payment by your office of $369.63 or payment at the 25% level…Additional funding at the 50% reimbursement level of $369.63 is due this code.”
    - The respondent states that “63042 also billed for L5-S1 level; reimbursed 50% fee schedule value, as multiple procedure ($1478.50 X 50% = $739.25). 63042-50 for this level, correctly reimbursed 50% this value as bilateral procedure = $369.63.”
    - A review of the operative report indicates “Revision lumbar spine surgery L3-4 bilaterally, L4-5 bilaterally, L5-S1 bilaterally with decompression discectomy and neural foraminotomy.”
    - According to CMS policy regarding bilateral procedures “Modifier 50 represents that the procedure was performed bilaterally. To report bilateral services, bill the code with the 50 modifier and a unit of one in the days/units field”

The Division finds the following:

- The requestor used modifier -50 “bilateral procedure” to CPT code 63042.
- The code description supports that this code is unilateral by definition; therefore, If performed on both sides of the spine (bilaterally), the requestor must append modifier -50. A review of the operative report supports a bilateral procedure was performed at L3-4, L4-5 and L5-S1.
- The requestor incorrectly billed for the bilateral procedure per CMS policy, only CPT code 63042-50 should have been billed for the initial level.
- The respondent paid for the disputed service based upon reason code “W1 and 59”.

In regards if additional reimbursement is due, the Division will use the following statute:

28 Texas Administrative Code §134.202 (c) states “To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:
(1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used.
(2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L:

(A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule;

(B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or

(C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.”

The Medicare allowable for CPT code 63042 in Bexar County is $1,182.80. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals $1,478.50. This code is subject to multiple procedure rule discounting of 50%; therefore, the MAR is $739.25. The requestor appended modifier “50” to designate that the procedure was performed bilaterally; therefore, $739.25 multiplied by 150% = $1,108.87.

The respondent paid $739.25 for 63042 and $369.63 for 63042-50 for a total of $1,108.87.

The difference between the MAR and amount paid is $0.00. As a result, the amount ordered is $0.00.

2. CPT code 63044 is defined as “Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure).”
   - A review of the submitted medical bill indicates that the requestor billed 63044, 63044-50, 63044-50, and 63044-99.
   - The requestor appended modifiers “50-Bilateral Procedure” and “99-Multiple Modifiers” to CPT code 63044.
   - The requestor states that “Code 63044-50 for bilateral revision decompression and discectomy at L3-L4, a fair and reasonable charge of $1125 as an add on-code has been made with payment by your office of $164.86. This is an add-on code and it is not to be reduced.”

     “Code 63044-99 concerning L3-L4 initial level, a fair and reasonable charge for the add-on code is $750 with payment of $329.71 at 50% reduction. Once again, this is an add-on code. It is not to be reduced.”

     “Code 63044 concerning level L4-L5. This is an add-on code. A fair and reasonable charge of $750 was made with payment by your office of $329.71, which is 50%. This is an add-on code and not to be reduced.”

     “Code 63044-50 concerning level L4-L5 bilaterally, a fair and reasonable charge of $1125 was made with payment of $164.86, which is a 25% payment…This is an add-on code and not to be reduced.”
   - The respondent states in the position summary that “This is a BY-REPORT code; per NCCI, carriers will establish payment amount for these services on an individual case basis following review of documentation.”
   - According to CMS policy regarding bilateral procedures “Modifier 50 represents that the procedure was performed bilaterally. To report bilateral services, bill the code with the 50 modifier and a unit of one in the days/units field

The Division finds the following:

- CPT code 63044 is an add-on code for CPT code 63042.
- As stated above in number 1, the operative report supports billing of the bilateral procedure.
- The requestor did not bill for the bilateral procedure in accordance with CMS policy.

In regards if additional reimbursement is due, the Division will use the following statute:

28 Texas Administrative Code §134.202 (c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

CPT code 63044 does not have a listed relative value unit or payment assigned by Medicare or Texas Medicaid and/or the carrier did not assign a relative value; therefore, this code is subject to fair and reasonable reimbursement.

28 Texas Administrative Code §134.1 which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the additional amount sought of $960.14 for CPT code 63044-50 and $420.29 for CPT code 63044-99 and 63044 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

3. CPT code 63011 is defined as "Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral."
    - The requestor appended modifier "50-Bilateral Procedure" to CPT code 63011.
    - The requestor states in the position summary that "CMS and TDI guidelines address these codes to be paid at 50%. Additional $300.37 is due this code."
    - The respondent states in the position summary that "MAR with mult procedure reduction & bilat reduction."
    - A review of the submitted medical bill finds that the requestor billed CPT codes 63011-59 and 63011-50.
    - The operative report indicates "Revision decompressive laminectomy of the sacrum bilaterally with decompressionof the caude equine and the S1 nerve roots bilaterally."
    - According to CMS policy regarding bilateral procedures "Modifier 50 represents that the procedure was performed bilaterally. To report bilateral services, bill the code with the 50 modifier and a unit of one in the days/units field.

The Division finds the following:

- The operative report supports billing of the bilateral procedure.
- The requestor did not bill for the bilateral procedure in accordance with CMS policy.

In regards if additional reimbursement is due, the Division will use the following statute:

28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

The Medicare allowable for CPT code 63011 in Bexar County is $961.18. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,201.47. This code is subject to multiple procedure discounting; therefore, $1,201.47 X 50% = $600.73. The requestor appended modifier "50" to designate that the procedure was performed bilaterally; therefore, $600.73 multiplied by 150% = $901.09.

The respondent paid $600.74 for 63011 and $300.37 for 63011-50 for a total of $901.11.

As a result, the amount ordered is $0.00.

4. CPT code 62290 is defined as "Injection procedure for discography, each level; lumbar."
   - The requestor appended modifiers "59-Distinct Procedural Service," "99-Multiple Modifiers," and "22-Increased Procedural Service" to CPT code 62290.
   - Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."
   - According to the explanation of benefits, the respondent denied reimbursement for this service based upon reason codes "97 and 903."
   - Per CCI edits, CPT code 62290 is a component of CPT codes 63042. A modifier is not allowed to differentiate the service.

   The Division finds that the allowance for CPT code 62290 is included in the allowance of another procedure performed on the disputed date. As a result, reimbursement cannot be recommended.

5. CPT code 63685 is defined as "Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling."
   - The requestor appended modifier "59-Distinct Procedural Service" to CPT code 63685.
   - According to the explanation of benefits, the respondent denied reimbursement for this service based upon reason codes "B12 and 112."
   - The requestor states in the position summary that "Code 63685-59 for implantation of EBI bone growth transmitter unit, a fair and reasonable charge of $650 was made with no payment whatsoever from your office with no reason give. Please see the operative report page 1, number 18 under implantation of EBI transmitter unit and the body of the operative report."
   - The respondent states in position summary that "63685 reportable for insertion of spinal neurostimulator pulse generator, utilized in conjunction with spinal leads/electrodes, for pain management. Not documented; pmnt denied."
   - The operative report states "The patient had a separate incision and implantation of bone growth stimulator units sewn in with #1 PDS suture."

   The Division finds that the requestor has supported billing of CPT code 63685; therefore, reimbursement is recommended.

28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

The Medicare allowable for CPT code 63685 in Bexar County is $350.46. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals $438.07. This code is subject to multiple procedure rule discounting of 50%; therefore, the MAR is $219.03. The difference between the MAR and amount paid is $219.03. As a result, the amount ordered is $219.03.

6. CPT code 22851 is defined as "Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)."
    - The requestor appended modifiers "59- Distinct Procedural Service," and "50-Bilateral Procedure" to CPT code 22851.
    - The respondent denied reimbursement based upon reason codes "309 and W1."
    - The requestor states in the position summary that "Code 22851-59 for cage placement at L4-L5, a fair and reasonable charge of $650 was made, but no payment whatsoever from your office with reasoning code exceeds allowance…This code is not be reduced. You have already paid code 22851 at L5-S1 at $495.16. An additional $495.16 is due to this code." "Code 22851-50 at L4-L5, a fair and reasonable charge of $950 was made with no payment whatsoever from your office with same reasoning."
    - The respondent states in the position summary that "3rd & 4th units not documented. Please refer to AMA/CPT guidelines; 22851 reportable 1 unit per vertebral interspace, not to be reported addtl units for bilateral placement…Also, per NCCI guidelines, bilateral reporting not applicable."
    - Per CMS policy, CPT code 22851 has a payment indicator of "0" for bilateral procedure. A payment indicator of "0" means "Bilateral does not apply".
    - The operative report indicates that the claimant underwent cage placement at L4-5 and L5-S1.

    The Division finds the following:
    - Per CMS policy, CPT code 22851 cannot be reimbursed as a bilateral procedure; therefore, the requestor's use of modifier"50" is inappropriate.
    - The operative report indicates that the claimant underwent cage placement at two interspaces. The respondent paid for two interspaces. As a result, reimbursement cannot be recommended for CPT codes 22851-59 and 22851-50.
7. CPT code 22842 is defined as "Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)."
    - The requestor appended modifier "50-Bilateral Procedure" to CPT code 22842.
    - The respondent denied reimbursement based upon reason codes "W1 and 552."
    - Per CMS policy, CPT code 22842 has a payment indicator of "0" for bilateral procedure. A payment indicator of "0" means "Bilateral does not apply";.
    - The operative report indicates "Posterior instrumentation segemental fixation L4, L5, S1 bilaterally with Crosslink L4-5 and Crosslink L5-S1."

    The Division finds the following:
    - Per CMS policy, CPT code 22842 cannot be reimbursed as a bilateral procedure; therefore, the requestor's use of modifier"50" is inappropriate
    - The respondent paid $931.86 for CPT code 22842-22.
    - The operative report indicates 3 vertebral segments. The documentation does not support billing of an additional CPT code 22842 .As a result, reimbursement cannot be recommended.
8. CPT code 22325 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar."
    - The requestor appended modifier "59- Distinct Procedural Service" to CPT code 22325.
    - The respondent denied reimbursement for code 22325-59 based upon reason code "W1."

- The requestor states in the position summary that "Code 22325-59 concerning reduction of subluxation at L5-S1, a fair and reasonable charge of $1850 was made at the 100% reimbursement level with no payment whatsoever from your office with no reason given…Additional $925 is due to this office concerning this code at the 50% reimbursement level."
- The respondent states that "As no separate fixation procedure (rod application, instrumentation, or fusion procedure) performed expressly for treatment of subluxation, these codes are not separately reportable with arthrodesis procedures X 2, rod instrumentation, & cage placement also billed & paid separately for this op session."
- The operative report states reduction of subluxation at L3-4, L4-5, and L5-S1.

The Division finds the following:

- The operative report supports a three level reduction.
- Per NCCI edits, no conflict between billing CPT code 22325 and arthrodesis codes 22558, 22585, 22612 and 22614; therefore, the respondent's denial of reimbursement is not supported.

28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

The Medicare allowable for CPT code 22325 in Bexar County is $1,230.03. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals $1,537.53. This code is subject to multiple procedure rule discounting of 50%; therefore, the MAR is $768.76. The difference between the MAR and amount paid is $768.76. As a result, the amount ordered is $768.76.

9. CPT code 22328 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (List separately in addition to code for primary procedure)."
   - The requestor appended modifiers "59-Distinct Procedural Service" and "22-Increased Procedural Service" to CPT code 22328.
   - The respondent denied reimbursement for this service based upon reason codes "W1 and 309."
   - The operative report states reduction of subluxation at L3-4, L4-5, and L5-S1.

   The Division finds the following:

   - CPT code 22328 is an add-on code from primary procedure code 22325.
   - The operative report supports a three level reduction.
   - Per NCCI edits, no conflict between billing CPT code 22328 and arthrodesis codes 22558, 22585, 22612 and 22614; therefore, the respondent's denial of reimbursement is not supported

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   The Medicare allowable for CPT code 22328 in Bexar County is $267.36. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals $334.20. This code is not subject to multiple procedure rule discounting; therefore, the MAR is $334.20. The difference between the MAR and amount paid is $334.20. As a result, the amount ordered is $334.20 for code 22328-59 and 22328-22.

10. CPT code 69990 is defined as "Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)."
    - The requestor appended modifies "59-Distinct Procedural Service" to CPT code 69990.
    - The respondent denied reimbursement for this service based upon reason codes "97 and 903."
    - Per NCCI edits, CPT code 69990 is a component of CPT code 63042.

The Division finds that the allowance for CPT code 69990 is included in the allowance of another procedure performed on the disputed date. As a result, reimbursement cannot be recommended.

11. The Requestor billed CPT code 22899-99 –"Unlisted procedure, spine."

    - The requestor appended modifier "99-Multiple Modifiers" to CPT code 22899.
    - The respondent denied reimbursement for this service based upon reason codes "97 and 243."
    - The requestor wrote in the position summary that "Code 22899-99 concerning examination under anesthesia and pain study… a fair and reasonable charge of $500 was made with no payment whatsoever from your office."
    - The Respondent wrote "Apparently billed for EUA & pain study; documented as customary examination & neuro response assessment performed after induction of anesthesia…Not separately reportable with other procedures this op session…Integral component for successful accomplishment of primary procedures; considered accepted standard of care for performance of the primary procedure; medically necessary to successfully complete the comprehensive service; not a separately distinguishable procedure; therefore not separately reportable per NCCI general principles."

    The Division finds the following:

    - The requestor did not submit a copy of the examination under anesthesia and pain study to support the billed study.
    - The requestor did not support position that the pain study was not a component of another procedure billed on the disputed date of service; therefore, the respondent's denial based upon reason codes "97 and 243" are supported.
    - Furthermore, CPT code 22899 does not have a listed relative value unit or payment assigned by Medicare or Texas Medicaid and/or the carrier did not assign a relative value; therefore, this code is subject to fair and reasonable reimbursement per 28 Texas Administrative Code §134.202 (c)(6).
    - 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds:

      - The requestor does not discuss or explain how reimbursement of $500.00 for code 22899-99 is a fair and reasonable reimbursement.
      - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
      - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
      - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

      The request for reimbursement is not supported. As a result payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,656.19.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,656.19 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	7/24/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.